A HANDBOOK FOR

nurse ~*to*~ nurse

REPORTING

REVISED THIRD EDITION

REVISED BY JILLIAN MACGUIRE

KING's FUND CENTRE

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The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

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Members of the original working party

Miss G M Law, Adviser for the Nursing Process, Department of Health and Social Security

Dr J M MacGuire, Student Nurse/Researcher, Shropshire

Mrs J North, Senior Tutor, Rotherham School of Nursing

Miss K Rea, Barrister and Nurse

Miss D Sayle, Community Midwife and Health Visitor, Norfolk

Mr A Smith, Principal Professional Officer, English National Board for Nursing Midwifery and Health Visiting

Miss S Whitfield, Nursing Officer (Nursing Process) City & Hackney Health Authority

Miss C Davies, Project Officer (Education and Training), King's Fund Centre

Miss H O Allen, Assistant Director (Education and Training), King's Fund Centre

Foreword

Nurse-to-nurse reporting is a critical part of good nursing practice in both primary and secondary health care settings.

The King's Fund published the first edition of this project paper in March 1979 and a revised edition in March 1983. It has sold over 10,000 copies.

This reflects the success of the original paper, and indicates a need for this type of information.

The work originated from a series of meetings entitled 'Nurses Reporting on Patients' which was held at the King's Fund Centre from 1973 to 1977. A small working-party formed from among the participants met regularly in order to produce some guidelines to the subject.

These guidelines were revised following a conference held at the Centre in 1982. While the basic ideas put forward in the original and revised editions are still useful, the way in which these ideas are expressed no longer fits easily with current practice. The guidelines have, therefore, been revised following visits to a number of wards to observe the nurse to nurse handover procedure, and a new introduction covering some of the ways in which information about patients is passed from nurse to nurse has been included.

Although the guidelines were originally written for nurses working in acute specialties, the principles for good nurse to nurse reporting also apply to other specialties and in primary health care.

All statements can refer equally to men and women.

Acknowledgements

We wish to thank all the hospitals and organisations as well as the many ward sisters, nurse tutors and student nurses who influenced the original thinking behind these guidelines.

For the present revision we should like to acknowledge the help given by the staff in the following wards where handovers were observed:

Hilton Main Ward and Hollybank Ward, Cannock Community Hospital, Cannock, Staffordshire

7e Nursing Development Unit, John Radcliffe Hospital, Oxford

Byron Ward, Nursing Development Unit, Kings College Hospital, Dulwich, London

Poplar Ward and Webb Ward, Royal Shrewsbury Hospital, Shropshire

Ward 33, The Nursing Development Unit, Tameside General Hospital, Ashton-Under-Lyne, Lancashire.

The revision has also benefited from the advice of Sandra Beevor, Brigid Reid, Bridgit Dimond and Karen Rea.

We appreciate also the advice and assistance extended to us by the Department of Health, the Royal College of Nursing and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

We have drawn heavily upon the successful work of those who produced the first edition. We hope that in developing their thinking we have done justice to the work they so ably began.

Introduction

Imagine you are going on to a ward for the first time or meeting a patient for the first time. How do you get to know who the patients are, what is wrong with them, what nursing care they need and what you are expected to do ? The nurse to nurse reporting system gives you information about the patients you will be looking after and information about what you should be doing for those patients.

The nurse to nurse reporting system differs from ward to ward and from organisation to organisation. There is no one right system. Each system has to be tailor-made for the particular situation. The essential guiding principle is common to all systems:

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Information must flow from those who know to those who need to know

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As this suggests, nurse to nurse reporting is always a two-way process of communication between two, or more, nurses about the nursing care of a particular patient.

A number of changes have taken place during the last ten years which have affected the way nursing work is organised. These changes, in turn, have brought about changes in nurse to nurse reporting systems. Some of these changes are as follows:

1. The use of the nursing process and its associated documentation has been widely adopted. This means that much more information about patients and their nursing care is written down. Care plans can be readily consulted. There is, therefore, less need for the traditional 'Ward Report' in which the standard details of all patients are read out to all staff.

2. Many wards have introduced some form of team nursing which means that information often needs only to be passed to the members of each team rather than to all staff. The team leader may take on the responsibility for briefing team members and for reporting back on the patients allocated to the team. Where patients are allocated to a 'key nurse' or to a 'primary nurse' this nurse will take on a pivotal role in communication with and about those patients.

3. There has been an increase in the number of part-time staff in many wards and a reduction in overlap between shifts. This means that if all staff are to be briefed when they come on duty the traditional pattern of formal ward report sessions is no longer adequate. Other ways of communicating information have had to be found.

4. The staffing structure of most wards has become much less hierarchical and the nurse 'in charge' of a ward at any particular time may not be the most senior nurse. The passing of information 'up' and the giving of instructions 'down' plays less part in the way wards are now organised.

Communication

How do we communicate?

Communication is about passing information between staff and between staff and patients. It is about more than the passing of facts, instructions and messages. It is also about the way people feel about their work, how they regard patients and relatives and how they respond to one another.

The skills needed by nurses to communicate effectively with patients, patients' families, colleagues and other members of the health care team are many and varied. As well as speaking, listening, reading and writing, they include the non-verbal methods used to convey meanings from one person to another. (see box 1)

Box 1

We communicate by ... :

- **what we say**
- **our tone of voice**
- **the use of pauses or silence**
- **the way we interrupt or talk over others**
- **the way we stand**
- **where we sit**
- **the way we walk**
- **the way we dress**
- **the hand movements we use**
- **facial expressions – smiles, frowns, grimaces**
- **the way we look at each other**
- **eye contact**
- **touch**
- **the sounds we make – sighing or laughing**

Box 2

Contributors to communication

We are often not aware of the nature and intensity of the non-verbal messages we are transmitting to others. Considerable anxiety is evoked in the person we are trying to communicate with when our verbal and non-verbal messages do not match. This is because the receiver of the communication has to decide which of two or more messages to respond to.

◆

We communicate more than we are aware of most of the time.

◆

An example of this kind of situation is where a nurse says to a patient 'How do you feel?' (inviting him to talk about himself) and at the same time edges away from him (showing than she is too busy to listen to what she expects will be a long and complicated reply). Often a patient will respond to the non-verbal message, mutter 'fine' and be unable to reveal some important change in the nature or severity of his symptoms.

◆

Remember that when made to choose between the verbal and non-verbal message, people will tend to act on the non-verbal one. This is particularly true of the very ill patient and of children. Non-verbal cues may also have different meanings for people from different cultural backgrounds.

◆

Nurses communicate all the time. They exchange ideas, information and feelings with patients, patients' families and with colleagues. Effective communication is a skill and is as important as the technical skills which nurses need to develop. Nurses constantly need to reinforce these skills in order to report accurately and concisely. One way of helping this is through the reporting and handover system.

Job satisfaction for nurses and patient satisfaction with nursing care are both increased by good communication.

A nurse who is able to communicate with a patient and is sensitive to what the patient is saying will be better able to identify her nursing problems, plan her nursing care and involve her and her family in that care.

New information relating to a patient's condition and his response to care is being obtained all the time. Such information must be available to those who are directly caring for him. Some of this may be communicated through the spoken word alone. Some may need to be written down. In this way it is incorporated into the formal system used for nurse to nurse reporting. This system, when used flexibly and creatively, is the key to nursing action.

◆

Not all the contents of communication between nurse and patient is relevant to care. Not all information has to be written down. Professional judgement and selectivity are involved.

◆

Formal communication

Formal nurse-to-nurse reporting is made up of spoken and written reports. The former may sometimes be available as a tape recording and the latter on a VDU screen or computer print-out.

Spoken reports

These reports are given and received at the handover between shifts or when individual staff come on duty, go for breaks or go home.

Also included are messages passed between staff during a shift and information received through telephone calls, laboratory reports, X-ray reports and letters.

Written records

Such records include:

- general information about a patient on arrival
- care plan for nursing action required
- daily record of a patient's progress
- observations required and/or carried out by a nurse.

This information may be recorded in the form of a patient history and assessment, progress reports, charts, ward record books or care plans. Most written nursing records are now consolidated in the form of a nursing care plan.

Other written records and letters might include information given to nurses outside the immediate work area, for example, senior night staff, or when a patient is being transferred or discharged, to community staff.

This handbook is concerned with spoken reports and the written record.

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Remember that neither you nor others can act without the necessary information. Others in the team are often dependent on what you said or wrote yesterday in deciding what they will do for a patient today.

◆

Spoken and written communications

The briefing given by one nurse to another is vitally important to patient care – whether it takes the form of a written or spoken briefing.

Definitions

Spoken communication refers to the spoken word only. No written record exists of such communications. You have only the memory of the speaker and the listener to rely on. If you make notes during a report this becomes part of the written record.

Box 3

Note on taped and computer-held records

Taped reports are a special form of spoken communication. While they may be referred to by several people during a shift they should not be retained from one shift to another. They are not an alternative to the written record.

Computer-held records have the same status as any other written records. Additionally they are subject to the Data Protection Act, 1984. Written records are dealt with in the Access to Health Records Act, 1990. Both acts cover access to records by patients and clients as well as matters of confidentiality and safe storage.

Written communication – refers to the spoken word that is written down as part of the formal record and to material that is written directly into the formal record or typed into a record held on computer.

The spoken report

Spoken communications need:

- to be accurate and concise, relating at all times to previous reports or problems identified
- consistently to use familiar terminology that is understood by all
- to involve only those who need to know
- to invite questions and discussion as means of clarification.

Some of the spoken material may need to be written down in the form of messages or aide memoires. You can't remember detailed information accurately. Some of the material may form the basis of entries in the permanent written records – it is crucial that it is correct.

Handover

All nurses need to receive a report on their patients before they start a period of duty. This may be given by the nurse who has been caring for a group of patients on the previous shift, the team leader, the named nurse, key nurse or primary nurse, or may be given by the ward co-ordinator or most senior nurse as appropriate in a particular ward setting.

Where there are detailed care plans only a brief spoken report may be needed, updating a patient's progress, and including significant changes or major events scheduled for the coming shift. It is often not necessary for all staff to hear about all the patients.

In order to be effective, efficient and safe spoken communications need:

- to be a two-way process
- to be supervised for accuracy and details if given by unqualified staff
- to be conducted in an undisturbed, quiet area of the ward
- to be audible to the participants and delivered in a simple, concise manner explaining unfamiliar terms to patients and learners where appropriate
- to involve teaching and discussion, in the form for example, of case conferences or patient centred tutorials

◆

Start by finding out how much your colleague already knows.

◆

All or part of the handover may be at a patient's bedside. This may be difficult to manage in such a way that a patient's privacy is maintained. The only justification for bedside handover is that it enables patients to participate. A murmured handover in the doorway of a bay or a round modelled on the medical round does not constitute 'bedside handover'

Transfer of patients

When patients are transferred between wards, from theatre or casualty departments, between hospitals or to community services nurses are usually involved in some form of spoken handover. Sometimes they may speak on the telephone or give a taped report. It is good practice to prepare for the transfer of a patient by checking:

- when the transfer is to take place
- where the patient is to go
- that the relatives have been informed
- that any property is transferred with the patient
- that notes, nursing records, drugs, observation charts, x-rays, care plans, drug charts and aids are all transferred with the patient.

Prepare your patient by:

- explaining why the transfer is taking place
- giving as much advance notice as possible
- telling relatives about the move.

The nurse caring for the patient should, whenever possible, conduct the transfer:

- by making a report to the nurse who will be caring for the patient
- by referring to the care plan and nursing records as a guide when reporting, to help with accuracy
- by concisely covering all aspects of care; physical, psychological and social
- without rushing the report as it is the only means of ensuring good continuity of care.

Telephone calls

The use of the telephone is as much a part of spoken communication as is the handover report; indeed, some handovers may be conducted by phone. Phone calls fall into two main groups:

- those from relatives and friends enquiring about a patient or wanting messages passed to a patient

- those between colleagues, medical staff, other wards or departments or with community staff in which information about a patient is relayed.

Where answering the phone is part of the role of a ward clerk, some ground rules have to be agreed about what kinds of calls can be dealt with directly by the ward clerk and which should be dealt with by a nurse. Some guidance also needs to be given to unqualified staff and learners about how they should deal with calls. This may well vary from one ward to another.

Enquiries about and messages for patients

Where possible callers enquiring about a patient should be put through to that patient so that he or she may deal with the call directly.

If this is not possible, the ward clerk or nurse needs to give accurate and individual information about a patient, having verified the identity of the caller if the voice is not recognisable. Where a patient has a named nurse, key nurse or primary nurse it may often be appropriate to arrange for that nurse, if not immediately available, to ring back. Patients should be consulted about what information they are willing to be given to which friends or relatives over the phone.

Specific details about diagnosis, findings at operation and biopsy reports are not usually given over the phone but, with the prior consent of a patient, this may sometimes be appropriate. If a patient's condition is serious the nurse or ward clerk should indicate to the family how quickly they need to come.

Messages for a patient should always be conveyed as soon as possible. With the patient's permission, the substance of the call may need to be relayed to the named nurse, key nurse or primary nurse where it is judged to be relevant to nursing care.

Information about patients

This should be passed to the relevant nurse as soon as possible. Detailed information, for example, results of investigations or contact numbers, should be written down and given to the appropriate nurse or, in some cases, written in the nursing record.

◆

As there is every chance you will forget the message, write it down.

◆

Box 4

Safe telephone usage requires ... :

- **permission from the patient when giving information by telephone**
- **confirmation by the nurse caring for the patient that information obtained may be given to the patient**
- **accuracy of detail when dealing with telephone information which involves:**

  - listening to the message
  - writing the message down
  - repeating it back to confirm accuracy
  - conveying it to the appropriate person as soon as possible
  - recording it, if appropriate, in the notes.

The nursing record

The nursing record is the only continuous written account of a patient's nursing care in hospital or the community and may provide information which is not available elsewhere. It is a confidential document and consists of:

- information about a patient, including background, lifestyle and nursing problems
- a written plan of nursing care
- a record of the care which has been given
- an assessment of the effectiveness of that care.

Sources of information about a patient

There are various sources from which information concerning a patient may be obtained. These include:

- the patient
- family and/or close friends
- the nurse's own observations
- other nurses who have cared for that patient
- medical staff and case notes
- other members of the health care team.

Written assessments, plans, actions and evaluations

There are several different formats for written assessments and plans, records of nursing actions and the evaluation of such interventions and for the recording of a patient's progress. Regardless of these differences, all should enhance continuity of care.

Documentation must be:

- **Legible**
- **Up-to-date** – changes in care must be recorded immediately
- **Unambiguous** – 'Push fluids' is an example of an instruction that is still frequently used. It may have a specific meaning for the nurse who gives the instruction but is open to many interpretations. The nurse taking on the care of a patient must know how much her patient should be encouraged to drink, how often and whether there are any restrictions on what may be drunk.
- **Accessible** – the documentation, wherever kept, must be readily available to all those looking after a patient.

Nursing care plans

Most patients have a written care plan which includes an assessment of needs, problems and capabilities, a statement of the short- and long-term goals the nurse and patient hope to achieve together, and the nursing interventions and patient involvement required to achieve those goals.

Nursing care plans are based on all the facts gathered during the nursing assessment of a patient and on the nurse's clinical knowledge. They therefore encompass the physical, psychological, social and spiritual aspects of a patient's care. They need to be revised as new information becomes available.

The patient and appropriate relatives or friends should be involved in the drawing up of the care plan unless circumstances dictate otherwise. The care plan is written by the nurse with the responsibility for a particular patient, but it is there for everyone working with that patient to see and use.

Care plans may be written in different formats and stored in different ways and places. Some wards may use pre-printed care plans while others may use specially prepared sheets which have pre-printed headings. In other wards care plans may simply be written out on blank paper.

Kardex or other records

Some forms of nursing record make use of a Kardex system as well as using individual care plans. The Kardex usually contains a summary statement recording significant events for each patient on each shift.

Separate books recording observations, bathing and patients' bowel movements were traditionally part of the nursing record but are outmoded and should no longer be kept.

Attention should be paid to keeping all the documentation for a particular patient together so that it provides a continuous and comprehensive record.

Whatever the form of the record, it should allow for:

- a clear statement of current problems
- a statement of current capacities
- significant observations
- changes in a patient's condition to be recorded
- changes in instructions to be entered
- entries showing that care has been delivered
- entries evaluating care.

There should be space for dating and timing entries, for the initials and signature of the nurse carrying out the care, and for the counter-signature of a senior nurse or mentor when work is undertaken by a learner or other unqualified staff member.

Writing the nursing record may be undertaken by a learner. It will provide experience in writing concisely, reviewing the nursing care given and anticipating a patient's future needs. However, the learner should be supervised until proficient and all written nursing records should be checked by the learner's mentor and countersigned.

Entries made by care assistants should be similarly monitored and countersigned.

Box 5

Written records

- **Information about a patient is written down so that it can be shared with all those involved in that patient's care.**
- **Written instructions about nursing care must be legible, up-to-date, unambiguous and be easily accessible to the nurses caring for a patient.**
- **Written records do help to ensure that a systematic picture of a patient's progress is available at all times and is not just held in the mind of one nurse.**

Keeping the record

Local policies exist to give guidance on which documents must be sent through to medical records when a patient is discharged or dies and which, if any, may be destroyed.

The nursing record is a record that will be of importance to a patient's care throughout his or her stay and during any later spells of treatment. It will form a permanent part of a patient's case folder together with other documents, like the general practitioner's original referral letter, the hospital medical record and social records.

Diagnostic reports such as microbiology, haematology and electrocardiograph reports are usually filed with the doctors' case notes.

Temperature, pulse and respiration and blood pressure charts may usually be destroyed when a patient is discharged as it is expected that observations considered significant at the time of recording will have been noted in the primary document.

Retention of personal health records

The retention of all personal health records is the responsibility of the health authority, and departmental guidance is contained in Department of Health circular HC(89)2O.

The written nursing record as a professional document

Box 6

The main purposes of the nursing record are:

- **To demonstrate that each patient receives the appropriate nursing care at a professionally acceptable standard.**
- **To maintain continuity and to provide a means of communication between the various disciplines concerned.**
- **To record any changes in the condition or circumstances of a patient.**
- **To provide a permanent record for future reference for research, teaching and investigation for legal purposes.**

The nursing record should demonstrate that nursing care is planned and is not simply an haphazard series of events. It should record the fact that planned care has been given, its effect and the general state of the patient.

It is a professional document and what is recorded by whom and the frequency of recordings is a matter for professional judgement in the light of local circumstances. Responsibility for the maintenance, content and standard of the nursing record rests with the individual qualified nurse – taking into account any specific guidelines which may be laid down by the health authority.

As in other areas of professional practice a nurse will be expected to maintain patient care records to professionally acceptable standards. The record should be complete and should demonstrate:

- a professionally acceptable standard of record keeping and
- a professionally acceptable standard of care.

When formulating local guidelines on nursing records, it is important that these concentrate on what is professionally acceptable and required in order to meet the primary purpose, that is, to provide a complete record of a patient's nursing care needs, progress and the care and treatment given or not given where this is significant. The guidelines should give clear indication of which nurse has responsibility for the completion and quality of the record. This will usually be the nurse actually giving the care to a patient.

The record and the nurse's duty of care

A nurse may be considered negligent if her acts or omissions fall short of the standard of her profession and if damage results to a patient. The nursing record will be important evidence if allegations of negligence are made.

Qualified nurses are responsible for their own record keeping and the counter-signature of the senior nurse on duty is not required. The records kept by ward staff should be monitored to ensure that clear and comprehensive accounts of patient care are being kept. Entries by unqualified staff should be scrutinised and countersigned.

Box 7

Safe recording practices

- Records should be completed as near the event or observation as possible.
- Entries in the written nursing record should be in indelible ink – replay ballpoints and pencil should not be used.
- Each entry should be dated and signed with the initials and full surname of the nurse writing it
- The time should also be noted for major events or changes.
- Errors should be crossed through and signed or initialled by the nurse correcting the error (as if it were a mistake in a cheque book).
- Correcting fluid or sticky-backed paper should not be used.
- The use of abbreviations and mnemonics can lead to misunderstandings and should be discouraged.
- Colour-coding should not usually be used – certain colours are difficult to read and can confuse where staff and records are mobile.
- The administration of controlled drugs need not additionally be noted in the nursing record unless it is an indication of a significant change in a patient's condition or care. There are separate controlled drug recording procedures.

Confidentiality and responsibility for storage of patients' nursing records

The nursing record is a confidential document (see UKCC standards for records and record-keeping). Access to it may be restricted but it should be available to nurses, doctors and paramedical staff. Patients must be asked for their consent before information is made available more widely.

Patients' records must always be kept in such a way as to minimise the likelihood of their going missing. In many wards patient care plans are kept at the foot of the bed or in patients' lockers while the Kardex is kept at the nursing station or in the office. In the community, care plans are often kept by patients/clients in their own homes while case-load data is kept at health centres or at local offices.

Additionally, if electronic storage and retrieval systems are in use nurses using a keyboard and VDU must be satisfied that they know how to operate the system, know the passwords for entry and know how to sign off. They must know and use the accepted modes for guarding against breach of confidentiality by any unauthorised person interfering with the system in any way.

Nurses need to be clear about the extent of their responsibility and this should be discussed with management and with representatives of professional bodies. It may be useful to hold an occasional ward seminar on these issues to ensure that there is common understanding among staff.

The nursing record and other components of a patient's record may be released by court order to legal, medical or other professional advisers of a patient either prior to or during legal action.

Box 8

C Consider what you want to say
O Organise your materials
M Make it brief
M Make use of others knowledge
U Use language others understand
N Never assume that 'everyone knows'
I Invite questions
C Clarify instructions
A Allow others to contribute
T Test the accuracy of your information
I Initiate opportunities for discussion
O Observe non-verbal cues
N Note down relevant information
S Show that you have understood

Suggested further reading

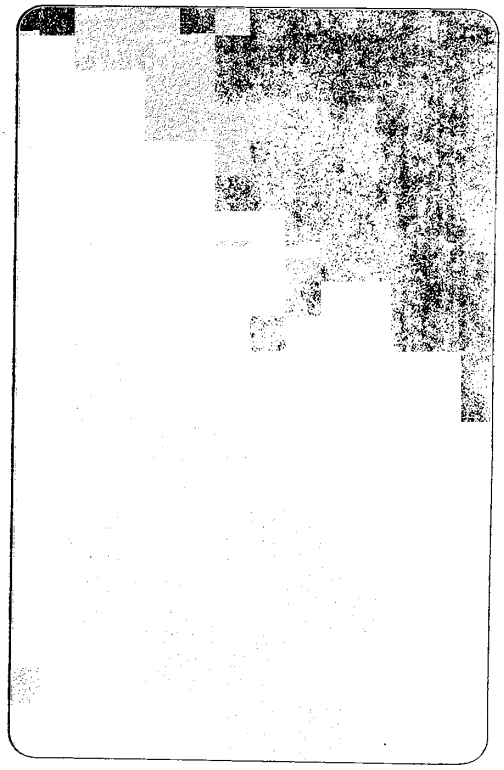
Bridge, W and Macleod Clark, J (editors). Communication in Nursing Care. London, H.M. and M. Publishers, 1981.

Dimond, B. Legal Aspects of Nursing. Prentice Hall, 1990.

UKCC. Confidentiality: An elaboration of Clause 9 of the Second Edition of the UKCC's Code of Professional Conduct for the Nurse, Midwife and Health Visitor. 1987.

UKCC. Standards for Records and Record Keeping. 1993.

Access to Health Records Act 1990: A guide for the NHS. Government Health Department, 1990.



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Nurse-to-nurse Reporting was first published in 1979 and has proved to be a very valuable source book for many nurses, having already sold more than 10,000 copies. The booklet has now been redrafted to take account of the changes which have taken place in the organisation of nursing practice over the last ten years, and offers up-to-date guidance on this important aspect of work.

Jillian MacGuire is Emeritus Professor of Nursing Research, University of Wales.

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